Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Western New York HCS - (VAMC Batavia - 528A4 and VAMC Buffalo - 528)

VISN 2

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 851

2. Point-in-time estimate of Veterans who are Chronically Homeless: 110

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **851** (point-in-time estimate of homeless veterans in service area) **X 17%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 74%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 110** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	406	30
Transitional Housing Beds	612	30
Permanent Housing Beds	750	60

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	We will participate in community PRISM project, a 24-hour survey to determine needs of homeless and chronically homeless. This will inform a local 10-year plan to end chronic homelessness.
Transitional living facility	Special project group will determine in which ways vacant building and green space on the Batavia VAMC campus could be utilized. HCHV and Veterans Industries submitted a project for a CWT-TR.
Help with Transportation	Community Project team will evaluate transportation issue and potential resources for change.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 64 Non-VA staff Participants: 69% Homeless/Formerly Homeless: 14%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.25	33%	2.25	1
2	Dental care	2.32	12%	2.34	2
3	Halfway house or transitional living facility	2.39	25%	2.76	8
4	Child care	2.46	0%	2.39	3
5	Help with transportation	2.55	2%	2.82	11
6	Help managing money	2.57	4%	2.71	7
7	Job training	2.59	10%	2.88	14
8	Guardianship (financial)	2.66	2%	2.76	9
9	Eye care	2.67	2%	2.65	5
10	Legal assistance	2.72	2%	2.61	4
11	Glasses	2.73	2%	2.67	6
12	Education	2.75	10%	2.88	13
13	Discharge upgrade	2.82	0%	2.90	15
14	Spiritual	2.87	12%	3.30	27
15	Emergency (immediate) shelter	2.95	21%	3.04	20
16	Help with medication	2.95	0%	3.18	24
17	SSI/SSD process	2.95	8%	3.02	19
18	Family counseling	2.96	0%	2.85	12
19	Welfare payments	2.98	0%	2.97	16
20	Help with finding a job or getting employment	3	9%	3.00	17
21	Help getting needed documents or identification	3	4%	3.16	23
22	Personal hygiene (shower, haircut, etc.)	3.02	2%	3.21	26
23	Treatment for dual diagnosis	3.07	4%	3.01	18
24	Drop-in center or day program	3.07	4%	2.77	10
25	VA disability/pension	3.11	2%	3.33	29
26	Detoxification from substances	3.15	0%	3.11	22
27	Hepatitis C testing	3.22	2%	3.41	32
28	AIDS/HIV testing/counseling	3.23	2%	3.38	30
29	Treatment for substance abuse	3.27	6%	3.30	28
30	Women's health care	3.28	0%	3.09	21
31	Clothing	3.31	10%	3.40	31
32	Services for emotional or psychiatric problems	3.31	6%	3.20	25
33	TB treatment	3.38	0%	3.45	33
34	TB testing	3.39	0%	3.58	36
35	Food	3.53	12%	3.56	35
36	Medical services	3.57	8%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.21	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.13	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.24	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.25	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.03	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.8	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.61	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.63	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.3	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.02	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.5	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.78	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.48	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.89	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.16	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.87	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.53	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.71	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.58	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Albany, NY - 500

VISN 2

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1200

2. Point-in-time estimate of Veterans who are Chronically Homeless: 292

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1200** (point-in-time estimate of homeless veterans in service area) **X 28%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 86%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 292** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	30	10
Transitional Housing Beds	106	15
Permanent Housing Beds	20	15

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 12

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	1. Two local providers have applied to VA Grant and Per Diem for enhancement grant with permanent housing assistance as a goal. 2. Local consortium agrees to become more aggressive about housing for low-income vets in safer neighborhoods.
Job Training	This identified need surprised us as VA and Department of Labor have great resources. Will market these programs more aggressively.
Help with finding a job or getting employment	Despite the economy, we have been very successful in job placement through VA Compensated Work Therapy and Department of Labor. Clearly we need to let the community be aware of these resources.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 50 Non-VA staff Participants: 58%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.41	8%	2.39	3
2	Long-term, permanent housing	2.44	33%	2.25	1
3	Help managing money	2.76	8%	2.71	7
4	Legal assistance	2.8	5%	2.61	4
5	Guardianship (financial)	2.87	0%	2.76	9
6	Dental care	2.96	7%	2.34	2
7	Welfare payments	3	3%	2.97	16
8	Family counseling	3.04	10%	2.85	12
9	Eye care	3.07	3%	2.65	5
10	Glasses	3.07	5%	2.67	6
11	Help with transportation	3.07	13%	2.82	11
12	SSI/SSD process	3.13	5%	3.02	19
13	Discharge upgrade	3.14	0%	2.90	15
14	Drop-in center or day program	3.15	8%	2.77	10
15	Education	3.15	5%	2.88	13
16	Job training	3.23	8%	2.88	14
17	Personal hygiene (shower, haircut, etc.)	3.26	0%	3.21	26
18	Spiritual	3.29	3%	3.30	27
19	Help with medication	3.3	3%	3.18	24
20	Emergency (immediate) shelter	3.36	8%	3.04	20
21	Clothing	3.4	5%	3.40	31
22	Halfway house or transitional living facility	3.42	10%	2.76	8
23	Treatment for dual diagnosis	3.43	8%	3.01	18
24	Women's health care	3.45	3%	3.09	21
25	Help with finding a job or getting employment	3.45	18%	3.00	17
26	VA disability/pension	3.48	3%	3.33	29
27	Detoxification from substances	3.5	8%	3.11	22
28	Help getting needed documents or identification	3.51	3%	3.16	23
29	Services for emotional or psychiatric problems	3.64	8%	3.20	25
30	Food	3.7	0%	3.56	35
31	AIDS/HIV testing/counseling	3.7	3%	3.38	30
32	Treatment for substance abuse	3.74	8%	3.30	28
33	Hepatitis C testing	3.76	0%	3.41	32
34	Medical services	3.85	3%	3.55	34
35	TB testing	3.89	0%	3.58	36
36	TB treatment	3.89	0%	3.45	33

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.88	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.5	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.17	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.24	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.34	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.13	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.98	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.05	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.21	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.88	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.55	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.88	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.45	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.34	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.53	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.77	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.37	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.13	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.33	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.4	1.84

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CHALENG 2004 Survey: VAMC Canandaigua, NY - 528A5, Bath, NY, Rochester, NY

VISN 2

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 45

2. Point-in-time estimate of Veterans who are Chronically Homeless: 4

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **45** (point-in-time estimate of homeless veterans in service area) **X 10%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 87%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 4** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	664	10
Transitional Housing Beds	28	6
Permanent Housing Beds	24	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Rochester Coalition for Homeless Veterans will address this issue at the next quarterly meeting scheduled for January 2005. New HUD Shelter Plus Care Programs are being managed by Veterans Outreach Center and by Unity Health "Project Impact." These programs will provide approximately 30 more slots for permanent affordable housing this coming year.
Help with finding a job or getting employment	Several initiatives are underway to help vets find employment. TEPS and the Veterans Industries program continue to work with veterans at two of our VA Grant and Per Diem programs. Linkages have also been established locally with VESID and "Rochester Works."
Help with Transportation	An initiative which requires the assistance of Regional Transit Service will be presented at the January meeting of the Rochester Homeless Veteran Coalition.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 21 Non-VA staff Participants: 76%
Homeless/Formerly Homeless: 5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.15	63%	2.25	1
2	Legal assistance	2.17	0%	2.61	4
3	Dental care	2.33	7%	2.34	2
4	Drop-in center or day program	2.4	20%	2.77	10
5	Child care	2.5	0%	2.39	3
6	Eye care	2.53	0%	2.65	5
7	Glasses	2.53	0%	2.67	6
8	Halfway house or transitional living facility	2.65	13%	2.76	8
9	Help with transportation	2.84	20%	2.82	11
10	Help managing money	2.88	0%	2.71	7
11	Guardianship (financial)	2.94	0%	2.76	9
12	SSI/SSD process	3	0%	3.02	19
13	Help with medication	3.05	0%	3.18	24
14	Detoxification from substances	3.11	0%	3.11	22
15	Job training	3.11	0%	2.88	14
16	VA disability/pension	3.18	0%	3.33	29
17	Personal hygiene (shower, haircut, etc.)	3.2	0%	3.21	26
18	Family counseling	3.28	0%	2.85	12
19	Spiritual	3.29	0%	3.30	27
20	Education	3.39	0%	2.88	13
21	Women's health care	3.41	0%	3.09	21
22	Discharge upgrade	3.41	0%	2.90	15
23	Treatment for dual diagnosis	3.42	7%	3.01	18
24	Welfare payments	3.44	0%	2.97	16
25	Emergency (immediate) shelter	3.45	13%	3.04	20
26	Medical services	3.45	0%	3.55	34
27	Help with finding a job or getting employment	3.53	31%	3.00	17
28	Services for emotional or psychiatric problems	3.58	7%	3.20	25
29	Treatment for substance abuse	3.6	7%	3.30	28
30	Hepatitis C testing	3.71	7%	3.41	32
31	Help getting needed documents or identification	3.72	0%	3.16	23
32	AIDS/HIV testing/counseling	3.78	7%	3.38	30
33	TB treatment	3.78	0%	3.45	33
34	Clothing	3.84	0%	3.40	31
35	TB testing	3.94	0%	3.58	36
36	Food	4.05	7%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.79	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.5	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.5	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.56	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.26	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.42	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.11	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.13	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.81	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.46	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.86	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.15	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.43	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.54	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.38	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.38	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.5	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.67	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.92	1.84

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CHALENG 2004 Survey: VAMC Syracuse, NY - 670

VISN 2

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 45

2. Point-in-time estimate of Veterans who are Chronically Homeless: 13

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **45** (point-in-time estimate of homeless veterans in service area) **X 34%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 87%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 13** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	252	0
Transitional Housing Beds	220	0
Permanent Housing Beds	65	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 5

3. CHALENG Point of Contact Action Plan for FY 2005

VA disability/pension	VISN 2 initiative will ensure each site will develop a process to ensure all homeless veterans in VA Grant and Per Diem programs will have opportunity for Veterans Benefits Administration screening. Coordination with the Buffalo VRO, NYS DVA, and other county, federal agencies planned.
Transitional living facility	Develop new Grant and Per Diem programs with Altamont Program, Lemoyne Manor, Liverpool, NY to provide 12 additional transitional beds for homeless veterans and job training opportunities.
Re-entry Services for Incarcerated Veterans	Implement pilot program at Mid-State Correctional Facility in Rome, New York to develop transitional support services for veterans returning to the community. These will include substance abuse/mental health services, employment and housing opportunities.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 25 Non-VA staff Participants: 64%
Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.05	38%	2.25	1
2	Child care	2.05	4%	2.39	3
3	Dental care	2.18	13%	2.34	2
4	Legal assistance	2.32	8%	2.61	4
5	Eye care	2.55	8%	2.65	5
6	Glasses	2.55	8%	2.67	6
7	Help managing money	2.8	0%	2.71	7
8	Help with transportation	2.8	0%	2.82	11
9	Education	2.86	0%	2.88	13
10	Halfway house or transitional living facility	2.95	38%	2.76	8
11	VA disability/pension	2.95	13%	3.33	29
12	Treatment for dual diagnosis	3	4%	3.01	18
13	Job training	3	8%	2.88	14
14	Family counseling	3.05	0%	2.85	12
15	Drop-in center or day program	3.09	0%	2.77	10
16	Guardianship (financial)	3.1	0%	2.76	9
17	Discharge upgrade	3.1	0%	2.90	15
18	Help getting needed documents or identification	3.11	4%	3.16	23
19	Welfare payments	3.14	0%	2.97	16
20	SSI/SSD process	3.18	0%	3.02	19
21	Help with finding a job or getting employment	3.18	8%	3.00	17
22	Emergency (immediate) shelter	3.22	33%	3.04	20
23	Spiritual	3.29	0%	3.30	27
24	Services for emotional or psychiatric problems	3.41	4%	3.20	25
25	Detoxification from substances	3.45	4%	3.11	22
26	Treatment for substance abuse	3.45	0%	3.30	28
27	Clothing	3.52	0%	3.40	31
28	Women's health care	3.54	4%	3.09	21
29	Personal hygiene (shower, haircut, etc.)	3.55	0%	3.21	26
30	Food	3.7	0%	3.56	35
31	Help with medication	3.9	0%	3.18	24
32	AIDS/HIV testing/counseling	4.05	0%	3.38	30
33	Medical services	4.22	0%	3.55	34
34	TB treatment	4.38	0%	3.45	33
35	TB testing	4.43	0%	3.58	36
36	Hepatitis C testing	4.43	0%	3.41	32

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.08	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.59	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.43	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.54	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.33	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.3	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.78	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.96	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.94	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.94	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.06	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.94	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.47	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.94	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.56	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.35	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.65	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.69	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.75	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.82	1.84